Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
PO BOX 24809
HOUSTON TX 77029

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-4824-01

MFDR Date Received
JULY 23, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has sent two status requests and a request for reconsideration, all of which have not been replied to. Therefore does not give us an avenue to properly seek reimbursement for services were provided. This is also in violation of Rule 133.304(a). The request for reconsideration and this MDR are being filed in order to comply with the requirements of **RULE §133.250**(B) and of **RULE §133.305**."

Amount in Dispute: $383.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were denied due to the fact 'the charges exceed the contracted/legislated fee arrangement.' The explanation of benefits further advised that 'this bill has been reviewed in accordance with the provider's contract with MedRisk. All contracted Physical Therapy and/or Chiropractic charges should be billed though [sic] MedRisk…' The bill was reprocessed on 02/12/2010, 04/08/2010, and 5/13/10. Each time the provider was advised to contract MedRisk."

Response Submitted by: American Home Assurance Co., PO Box 25974, Shawnee Mission, KS 66225

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 29, 2009	Physical Therapy Services	$383.00	$224.59

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the procedure for reimbursement of professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits:

- 1, (45) – Charges exceed your contracted/legislated fee arrangement.
- 1, (18) – Duplicate claim/service.

Issues

1. Did the requestor ?
2. Was the [issue 2 *** Tip: write the findings first and then come back here and write the questions that correspond to each numbered finding. The last sentence of each finding should answer the question asked in the issue here.]?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203(b)(1) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.
    - CPT Code 97002 is a component procedure of CPT Code 97112. The use of an appropriate modifier may be allowed; however, review of the medical bill finds that the requestor did not attach a modifier to this component code. As a result, the amount ordered is $0.00.

    The insurance carrier reduced or denied disputed services with reason code 45 – "Contract/Legislated Fee Arrangement Exceeded." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

    28 Texas Administrative Code §134.203(c) states, in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications (1) … For surgery when performed in a facility setting, the established conversion factor to be applied is $66.32… (2) Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The MAR for the payable services may be calculated by (2010 TDI-DWC Conversation Factor / MEDICARE CONVERSION FACTOR) x Facility Price = MAR.

    - CPT Code 97035 – (54.32 ÷ 36.8729) x $11.74 x 1 unit = $17.29
    - CPT Code 97110 – (54.32 ÷ 36.8729) x $28.48 x 3 units = $125.87
    - CPT Code 97112 – (54.32 ÷ 36.8729) x $29.07 x 1 unit = $42.83
    - CPT Code 97140 – (54.32 ÷ 36.8729) x $38.60 x 1 unit - $38.60

2. Review of the submitted documentation finds the requestor has supported reimbursement for the treatment rendered to the injured employee.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $224.59.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $224.59 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		April 26, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.